

If you need more space, use Item 9. Then go to Items 8 and 10.

Send to: State Review Team ND Department of Human Services 600 E Boulevard Ave, Dept. 325

Bismarck, ND 58505 Fax: (701) 328-1544

Note: This form has 8 pages.

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Nar	ne of Claimant or Beneficiary	Blind	Not Blind	Name of Wage Earne	er (If other than Claimant or Beneficiary)
Cla	imant or Beneficiary is Receiving:				
	Social Security Disability Insurance (SSDI) E	Benefits	E	Both SSDI and SSI Dis	ability Benefits
	Supplemental Security Income (SSI) Disabil	ty Benefits	1	Neither SSDI or SSI Di	sability Benefits
	PART I - TO BE COMP	PLETED BY TI	HE DEPART	MENT OF HUMAN	SERVICES
1.	Please use this form to describe your work ac	tivity since			Date (to be entered by SRT)
2.	2. We need to know this information to determine periods of actual work activity as opposed to periods of just employment (i.e. sick leave, vacation pay, etc.)				
ΙA	NSWER THE QUESTIONS ON THIS FOR THE STATE REVIEW TEAM AT THE AI				
	PART II - TO BE COMPLET	ED BY PERSO	ONS APPLÝ	ING FOR OR RECE	IVING BENEFITS
sho	u should answer each of the questions below as ould get or keep getting benefits. For any questi nber of the question that you are answering in i	on below, if you			
1.	HAVE YOU WORKED SINCE THE DATE SHO	OWN IN ITEM 1	OF PART 1, A	BOVE?	
	YES If you did work, go to item 3 and ar	nswer the rest o	f the questions	s and sign and date the	e form.
	NO If you did not work, but earnings w	ere reported for	you as showr	n in item 2 of Part I abo	ve, go to item 2 below.
2.	REPORT WORK OR EARNINGS If you did not work, but earnings were reported for example, sometimes pay is sick pay, vaca to work because of your condition. If you can't explain the earnings reported for y Explanation of Earnings	tion pay or holic	day pay that yo	ou earned, or for work	that you did before becoming unable

3.	3. TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE. (If you are not sure about some things, ask your employer to help you. If you need more space, use item 9, on Pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)					
	Employer's Address (Include street	, city, state and zip code)				
A.						
		<u> </u>				
	Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay		
	Number of Hours Worked (on average) Supervisor's Name Supervisor's Telephone Number					
	Number of Hours Worked (on avera		Supervisor's Name	(Include area code)		
		PER DAY PER WEEK				
	Check each block below that is true	e for this work:				
	I stopped working within 6 months, type of work I was doing (i.e. You w	or I reduced my work hours and vere a plumber and changed to	d earnings within 6 months, or within lighter work.) because	6 months I had to change the		
	of my medical condition.					
	special conditions at work rela	ated to my medical condition tha	t allowed me to work were removed.			
	•	•		an maaaana wana balawa)		
	i stopped working or changed	the type of work I was doing for	other reasons. (Tell us what the other	er reasons were below.)		
	Employer's Address (Include street	t city state and zin code)				
В.	Employer exteditions (morade street	i, oity, otato and zip oodo)				
	Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay		
	Number of Hours Worked (on avera	age)	Supervisor's Name	Supervisor's Telephone Number (Include area code)		
		PER DAY PER WEEK		(molado aroa oodo)		
	Check each block below that is true	e for this work:	•			
	I stopped working within 6 months, type of work I was doing (i.e. You w		d earnings within 6 months, or within lighter work.) because	6 months I had to change the		
	of my medical condition.					
	special conditions at work rela	ated to my medical condition tha	t allowed me to work were removed.			
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_	Employer's Address (Include street	t, city, state and zip code)					
C.							
	Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay			
	Number of Hours Worked (on avera	age) PER DAY PER WEEK	Supervisor's Name	Supervisor's Telephone Number (Include area code)			
	Check each block below that is true	e for this work:					
		or I reduced my work hours and		within 6 months I had to change the			
	of my medical condition.						
	special conditions at work rela	ated to my medical condition tha	t allowed me to work were rer	noved.			
	I stopped working or changed	I the type of work I was doing for	r other reasons. (Tell us what t	he other reasons were below.)			
		j.	`	,			
	Employer's Address (Include street	t city state and zin code)					
D.	Employer's Address (include street	i, city, state and zip code)					
υ.							
	Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay			
	Number of Hours Worked (on average)	lage)	Supervisor's Name	Supervisor's Telephone Number			
		PER DAY PER WEEK	·	(Include area code)			
	Check each block below that is true	e for this work:					
	I stopped working within 6 months, or I reduced my work hours and earnings within 6 months, or within 6 months I had to change the type of work I was doing (i.e. You were a plumber and changed to lighter work.) because						
	of my medical condition.						
	special conditions at work related to my medical condition that allowed me to work were removed.						
	special conditions at work rela	ted to my medical condition that	allowed me to work were rem	oved.			
	-	•					
	-	ted to my medical condition that the type of work I was doing for					
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Ε.	Employer's Address (Include street	i, city, state and zip code)				
	Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay		
	Number of Hours Worked (on avera	lge) PER DAY PER WEEK	Supervisor's Name	Supervisor's Telephone Number (Include area code)		
Check each block below that is true for this work:						
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	of my medical condition.					
	special conditions at work rela	ated to my medical condition tha	t allowed me to work were removed.			
		•	other reasons. (Tell us what the oth			
	l stopped treatming or ottoming an	,p	(,		
	Employer's Address (Include street	city, state and zip code)				
F.		, 6.1, 6.1.1.1.2.1.				
	Date Work Started	Date Work Ended	Starting Hourly Pay	Current or Ending Pay		
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		PER DAY PER WEEK		(Include area code)		
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	of my medical condition.					
	special conditions at work rela	ated to my medical condition tha	t allowed me to work were removed.			
	I stopped working or changed	the type of work I was doing for	other reasons. (Tell us what the other	er reasons were below.)		

Pag	ge 5						
3.	TELL US ABOUT YOUR WORK SINCE THE DATE IN ITEM 1 OF PART 1 ABOVE. (If you are not sure about some things, ask your employer to help you. If you need more space, use item 9, on Pages 5 and 6. Remember to write the number of the question that you are answering in Item 9.)						
G.	Employer's Address (Include street, city, state and zip code)						
	Date Work Started	Date W	/ork Ended	Starting Hourly Pay		Current or	Ending Pay
	Number of Hours Wor	ked (on average) PER [DAY PER WEEK	Supervisor's Name		Supervisor (Include ar	r's Telephone Number rea code)
	of my medical co	ing (i.e. You were a pondition. s at work related to m	lumber and changed to	nd earnings within 6 mon b lighter work.) because at allowed me to work we r other reasons. (Tell us	ere removed.		•
4.	you earned over \$200 No (Go to It Yes (Tell us) per month through 1 em 5.) which month and yea	2/2000 or over \$530 be r and the amount you ϵ	tem 1of Part 1, above, hat eginning 01/2001 (before earned that month in the lamber of the question that	anything was	withheld; of you need it	e.g., taxes)? more space, use
	MONTH/YEAR	AMOUNT	MONTH/YEAR	AMOUNT	MONTH	I/YEAR	AMOUNT
		\$		\$			\$
		\$		\$			\$
		\$		\$			\$
		\$		\$			\$
5.	SPECIAL WORK CO	NDITIONS - Do (Did)	you get special help or	 n-the-job or extra pay in a	any of the jobs	that you to	old us about in Item 3?
Э.	NO (Go to Ite	m 6.)					
		of the boxes that are andition(s) or help that		for which job(s) you rec	eived that help	and tell us	s about any other
	I needed in doing r	and got special help t ny job.	from other workers	I was given a job b to an employer.	ased on my p	ast service	s
		en special equiment on suited to my condition		I worked irregular	hours or took t	frequent re	st periods.
	I was allo productiv	wed to work at a lowe	er standard of	I worked in a shelt	ered work cen	iter.	
	I worked	for a relative or friend	l.	I was hired through (e.g., vocational re			

_	SPECIAL	WORK	CONDITIONS	- Continued
^		VVOIN	CONDITIONS	- Comunica

Check all of the boxes that are true for you and tell us for which job(s) you received that help and tell us about any other special condition(s) or help that you got on a job.

My job duties were different than other workers' job duties doing the same work because:

I worked fewer hours. I got different pay.

I had different duties; fewer or easier duties.

I had extra help, extra supervision, or a job coach.

I was given special transportation to and from work. I got special help getting ready for work.

I was paid extra rest periods at work or extra time off from work and other workers were not.

Other special help. (Explain below.)

In the spee below, tell us for which job(s) you received the special help. If you need more space, use Item 9.

6. OTHER/SPECIAL PAYMENTS - Do (Did) you get any payment(s) from an employer in addition to regular pay? For example, did you get any tips, bonuses, sick or disability pay, vacation pay, meals, room or rent, transportation or use of a car or vehicle, or childcare?

No (Go to Item 7.)

Yes Tell us below what these payments were. If you need more space, use Item 9.

EMPLOYER	TYPE OF PAYMENT	AMOUNT OR ESTIMATE OF THE DOLLAR VALUE	MONTH & YEAR
		\$	
		\$	
		\$	
		\$	
		\$	

7. SPECIAL WORK EXPENSES (IMPAIRMENT-RELATEDWORK EXPENSES) - Do (Did) you spend any money of your own earnings for any things or services related to your condition that allowed you to work and for which you did not get paid back?

For example, medicines, bandages, braces, wheelchair, artificial arm or leg, brialle equipment, special telephone or computer equipment, modifications to home (wider dorrways, roll-in shower, ramps, wheelchair-lift), or modifications to a car (automatic wheelchair-lift), personal assistance (personal care attendant.)

No Go to Item 8.

Tell us below about the bills, or part of the bills, that you paid for things or services related to your medical condition that you needed in order to work. (Upon review, you may be required to provide proof of these expenses.) <u>Do not show any bills or amounts paid by an insurance company</u> or any other organization or person <u>or paid to you by an insurance company</u> or other organization or person. (Example: An insurance company might pay all or part of the bill at a later time.)

7.	SPECIAL WORK EXPENSES (IMPAIRMENT-RELATEDWORK EXPENSES) - Continued				
	ITEM OR SERVICE		COST	DATE(S) PAID (MONTH & YEAR)	
		\$			
		\$			
		\$			
		\$			
		\$			
		\$			
	SPECIAL TRANSPORTATION		COST	DATE(S) PAID (MONTH & YEAR)	
	MODIFIED VEHICLE	\$			
	TAXI-TYPE SERVICE	\$			
8.	VOCATIONAL REHABILITATION - Are (Were) you get to get the services and/or training you need to get rea				
	No If you answered no, would you like to get	these servic	es? Yes	No (Go to Item 10.)	
	Yes Tell us the name and address of the peoper services and training.	ple who are (were) giving you vocational i	rehabilitation or employment	
	Vocational Re	habilitation/E	mployment Services Provide	Pr	
	Name		Address (Include street, cit	y, state & zip)	
	Counselor's Name		Counselor's Telephone Nu	mber (Include area code)	
		ed more spa	ce, go to Item 9, below.		
9.	More Space. For any question above, if you need mo you are answering before you begin.	-		er to write the number of the question that	

9.	More Space - (Continued) For any question above, if you need me the question that you are answering before you begin.	ore space, use the space below. Remember to write the number of
10.	I authorize any employer, agency or other organization to disclose entitlement to disability benefits any information about my medica	
	SIGN AND DA I certify under penalty of law that the information on this form	TE THIS FORM is true.
	Signature of Claimant, Beneficiary or Representative	Date
	Address (Include street, city, state and zip code)	Telephone Number
	Witness must sign ONLY if this statement is signed by mark (i.e., who know the person making the statement must sign below, giving	
	1. Signature of Witness	2. Signature of Witness
	Address (Include street, city, state and zip code)	Address (Include street, city, state and zip code)
	Telephone Number	Telephone Number